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1 Can we use biomarkers of coagulation to predict which patients with foot and
2 ankle injury will develop deep vein thrombosis?

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1. Abstract

Background

Our aim was to determine whether plasma levels of Tissue Factor (TF), Vascular Cell Adhesion Molecule 1 (VCAM-1), Interleukin 6 (IL-6) or D-dimer after foot and ankle injury could predict which patients would develop deep vein thrombosis (DVT).

Methods

Patients aged 18-60 years with acute foot and ankle injury had venous blood sample to measure TF, VCAM-1, IL-6 and D-dimer within 3 days of injury. Patients had bilateral lower limb venous ultrasound to assess for DVT on discharge from clinic.

Results

21 of 77 patients were found to have DVT (27%). There was no statistically significant association between levels of TF, VCAM-1, IL-6 or D-dimer and subsequent development of DVT.

Conclusion

Tissue Factor (TF), Vascular Cell Adhesion Molecule-1 (VCAM-1), Interleukin-6 (IL-6) and D-dimer levels were not associated with development deep vein thrombosis in patients with acute foot and ankle injury.

Keywords: Biomarkers, D-dimer, Tissue factor, Interleukin 6, Vascular Cell Adhesion Molecule 1, Venous thrombosis

1 2. Introduction

2 Patients with foot and ankle trauma treated with leg casts are at risk of venous
3 thrombosis (VTE). Tissue injury results in activation of the coagulation
4 cascade through initiation of the extrinsic coagulation pathway. The primary
5 cellular activator of this process is tissue factor (also known as TF,
6 Thromboplastin, Coagulation factor III), which is released by tissues in
7 response to injury [1]. Tissue factor acts as the co-factor for factor VII. The
8 combination of these results in activated VIIa, which activates factors X and IX
9 [2]. Factors VIIa and Xa subsequently result in activation of prothrombin to
10 thrombin, which subsequently results in formation of a fibrin clot from
11 fibrinogen. Fibrin clots cause haemostasis, and are subsequently broken
12 down by the action of plasmin into d-dimer products [3]. In a rabbit model,
13 Himber et al demonstrated that inhibition of tissue factor inhibited venous
14 thrombosis propagation [4]. However, despite these findings, there are limited
15 numbers of studies which have investigated the association between TF and
16 subsequent development of VTE. Similarly, many studies have shown that
17 patients who undergo lower limb venous ultrasound and subsequently found
18 to have deep vein thrombosis (DVT), also have significantly higher d-dimer
19 levels than those with normal imaging [5].

20

21 Recently, blood tests including Inflammatory cytokines such as Interleukin 6
22 and adhesion molecules including Vascular cell adhesion molecule 1 (VCAM-
23 1) have been found to be associated with development of venous thrombosis
24 [3, 6]. However, it is not known whether this is a cause or a consequence of

1 thrombosis. Cheng et al found that IL-6 levels significantly increased on day 1
2 after total knee replacement when compared to pre-operative levels,
3 suggesting that tissue injury activates inflammation [7]. In view that IL-6
4 creates a prothrombotic state by increasing the expression of tissue factor, it
5 is logical to consider that tissue injury may result in venous thrombosis [8].
6 VCAM-1 levels are increased at sites of endothelial inflammation and are
7 involved in leukocyte adhesion and migration across vascular endothelium.

8

9 Our aim was to determine whether tissue factor, interleukin 6, VCAM-1 or D-
10 dimer in the early injury period could predict subsequent development of DVT
11 in patients with acute foot and ankle injury treated with below knee cast.

12

13 3. Methods

14 As part of the Active Toe Movement study (AToM), adult patients presenting
15 to the Emergency Department at University Hospital of Wales with lower limb
16 trauma requiring treatment with a below knee non weight bearing cast for at
17 least 1 week were assessed for eligibility [9]. Only patients considered low risk
18 for VTE after assessment were eligible (Table 1).

19 All patients were recruited within 72 hours of injury, none were provided with
20 chemical thromboprophylaxis. At time of enrolment to the study, 3.5ml of
21 venous blood was taken using standard Vacutainer technique into a 3.2%
22 sodium citrate coagulation tube. This was centrifuged at 1500 rpm for 15
23 minutes and the supernatant plasma was frozen at -70 degrees centigrade

1 within 1 hour of blood being withdrawn. Participants were managed in the
2 fracture clinic with lower limb cast immobilization according to their injury. On
3 discharge from clinic, patients underwent bilateral lower limb ultrasound scan
4 to assess for above and below DVT. Deep vein thrombosis at the level of the
5 popliteal vein or more proximal was termed above knee, whereas thrombosis
6 below the level of the popliteal vein was considered below knee. All
7 assessments were performed by medical physicists who perform these
8 venous ultrasound studies as part of their role in the National Health Service,
9 all with a minimum of 5 years experience. After the last patient was
10 discharged from clinic, blood samples were thawed and analysed. Plasma
11 was tested for quantitative levels of Human Coagulation Factor III/Tissue
12 factor, Interleukin 6 (IL-6), VCAM-1 and D-dimer. We used the Quanikine
13 ELISA Immunoassay kits (R&D Systems) for each test according to the
14 manufacturers instruction. All kits were stored between 2 and 8 degrees
15 centigrade and used before their expiry dates. Calibrators were used and
16 diluted according to assay standard operating protocols in order to reference
17 test results. After incubation with ELISA microplates, samples were analysed
18 using an optical microplate reader. A standard curve was created using
19 calibration diluent results, from which test sample results were calculated. D-
20 dimer results were analysed in batch using a fully automated, bench-top,
21 random access analyser (ACL TOP 700) after calibration and internal quality
22 control using quality control plasmas at low and high control levels. All tests
23 were performed with the assistance of 2 experienced laboratory technicians,
24 who were blinded to the DVT status of the patient. Funding for consumables
25 to conduct this study was provided by AO UK.

1 Statistical analysis

2 Test for normality were performed using Kolmogorov Smirnov test. Unpaired
3 t-tests were used to test for statistical significance between Group 1 (DVT)
4 and Group 2 (No DVT) where data was parametric. Mann Whitney U test was
5 used for non parametric data.

6

7 4. Results

8 77 patients were recruited. The majority were male (n=50). Patient
9 demographics and injury types are displayed in Table 2. 27% (n=21) of the 77
10 patients were found to have asymptomatic DVT on bilateral lower limb venous
11 ultrasound scanning, all of which occurred in the lower limb that had been
12 injured and treated in cast. 2 of the DVT's were above knee (prevalence
13 2.6%), the rest were below knee (25%).

14 Tissue factor was normally distributed, therefore unpaired students t-test was
15 used to assess for statistically significant differences between Group 1 (No
16 DVT) and Group 2 (DVT) (Mean 23.92 pg/mL v 20.33 pg/mL, p=0.422). 18
17 patients (23%) had TF levels >35pg/mL, 3 of these subsequently developed
18 DVT. TF levels ranged from 0 to 68pg/mL. There was no significant difference
19 in Interleukin 6 levels between Group 1 (median 3.91 pg/mL) and Group 2
20 (median 4.59 pg/mL), p=0.764, range 0 to 84.68 pg/mL). Median values for
21 VCAM-1 were also similar between groups (552.98 v 496.84 ng/mL, p=0.111).
22 VCAM-1 levels ranged from 412.63 to 823.15 ng/mL. Although there was a
23 trend for median D-Dimer to be higher in those who subsequently sustained

1 DVT, this was also non significant ($p=0.490$). Results are displayed in Table
2 3.

3

4 5. Discussion

5 The prevalence of deep vein thrombosis in our study was 27% ($n=21$), all of
6 which occurred in the lower limb that had been injured and treated in cast. 2
7 of the DVT's were above knee (prevalence 2.6%). This is higher than found in
8 the recent study by Ho et al, which reported an overall DVT prevalence of
9 11% in non-surgically treated patients with foot and ankle fractures (1.4%
10 above knee) [10]. None of the plasma biomarker levels tested in our study
11 (Tissue Factor, Interleukin 6, VCAM-1 and D-Dimer) predicted subsequent
12 development of DVT.

13

14 In our study, Tissue factor levels were 23.92pg/ml in patients who did not
15 subsequently develop DVT, compared with 20.33pg/ml in those who did
16 ($p=0.422$). However, in contrast to our study findings, Walenga et al (2014)
17 found that those who developed VTE did have significantly higher tissue
18 factor levels (median 49.05 pg/mL vs 14.86 pg/mL, $p = 0.003$). This difference
19 was present at baseline, between 10 to 14 days post injury and at time of cast
20 removal [11]. Interestingly, at time of injury, levels were not elevated above
21 normal (<35 pg/mL) (11). 18 patients (23%) in our study had TF levels
22 >35 pg/mL, 3 of which subsequently developed DVT.

23

1 In our study, median IL-6 levels were 3.91 pg/mL in those who did not
2 subsequently develop DVT and were 4.59 pg/mL in those who did develop
3 DVT ($p=0.764$) (range 0 to 84.68 pg/mL). In a study by Mosevoll et al (2015),
4 the R&D systems Luminex assay kit was used to measure inflammatory
5 markers in plasma of patients suspected of having lower limb DVT [6]. They
6 found no significant difference between IL-6 levels in those with (1.240 pg/ml),
7 compared to those without (2.020 pg/ml) DVT on subsequent venous USS.
8 Furthermore, IL-6 levels in the 21 patients found to have DVT on USS, were
9 not significantly higher than 20 normal control patients without DVT (1.240
10 pg/ml vs 3.470 pg/ml. $p=0.1967$) [6]. In contrast, in a series of 40 patients with
11 phlebographically proven lower limb DVT, Roumen-Klappe et al (2002)
12 measured IL-6 on day of presentation and compared levels to a group of 33
13 controls. They also measured IL-6 on the subsequent 5 days following DVT
14 and found that IL-6 levels were significantly higher in the group with DVT
15 (15pg/mL, range <3 to 70 pg/mL) as compared with the control group (<3
16 pg/mL, range <3 to 11 pg/mL), but subsequently decreased during the
17 following 5 days, to 5.5 pg/mL by day 5 ($p < 0.01$). This indicates that that the
18 raised IL-6 levels were the result of thrombosis rather than the cause [12]. At
19 32 months after DVT, patients continue to have increased levels of IL-6
20 compared to controls, suggesting a persistent chronic sub-clinical response
21 [13]. In view of that there were no significant differences in IL-6 between those
22 who did and did not develop DVT in our study, this may represent that none
23 had DVT at the time of measurement. We would agree with the
24 aforementioned study authors that IL-6 levels are raised in response to DVT
25 rather than being the cause.

1 In a study of 135 patients suspected of having DVT, Bozic et al (2002) used
2 R&D Systems quantitative ELISA to measure plasma VCAM-1. The 39%
3 percent of patients who were subsequently found to have DVT on lower limb
4 doppler ultrasound, had significantly higher VCAM-1 levels (392
5 micrograms/litre vs 417 ($p=0.03$). However, VCAM-1 was not as accurate as
6 D-dimer in diagnosis using ROC analysis (0.6 vs > 0.8 depending on D-dimer
7 method used) [14]. In a similar recent study of 89 patients suspected of
8 having DVT, Mosevoll et al (2015) measured VCAM-1 using R&D systems
9 Luminex assay. VCAM-1 levels were significantly higher in the 21 patients
10 who were subsequently found to have DVT on lower limb ultrasound (850.161
11 ng/ml, range 104.311 to 1571.607 vs 635.436, range 290.605 to 2793.862,
12 $p=0.0009$). Furthermore, in comparison to 20 control patients, VCAM-1 levels
13 were also significantly higher in patients with DVT [6]. In our study, median
14 VCAM-1 levels were 552.98 ng/mL in those who did not develop DVT, as
15 compared with 496.84 ng/mL in those who did ($p=0.111$). In our study, VCAM-
16 1 levels ranged from 412.63 to 823.15 ng/mL. In a recent mouse model,
17 thrombin was shown to induce the expression of VCAM-1, suggesting that
18 VCAM-1 is increased prior to fibrin clot formation [15]. Levels of VCAM-1 may
19 therefore increased before levels of D-Dimer rise. The difference with our
20 study is that we measured VCAM-1 within 3 days of injury, as opposed to at
21 time of diagnosis of DVT. This may have been too early, before a pro-
22 thrombotic state had occurred.

23 In our study, D-Dimer levels were only 203.5 ng/mL in those who did not
24 develop DVT and 236 ng/mL in those who did ($p=0.490$). Levels ranged from
25 31 to 1184 ng/mL. Although it is not possible to draw direct comparisons

1 between our absolute D-dimer levels and those found by others due to
2 differences in methods used to quantify D-dimer, it is evident that levels in our
3 study are relatively low [16]. Many studies have shown that patients who
4 undergo lower limb venous ultrasound and subsequently found to have deep
5 vein thrombosis (DVT), also have significantly higher d-dimer levels than
6 those with normal imaging [14]. Recently, a d-dimer result of <500ng/ml was
7 shown to have a negative predictive value of 99.48% irrespective of clinical
8 suspicion of DVT [17]. In patients who have undergone surgery, cut off levels
9 for excluding DVT are higher. Abraham et al (1999) found that a d-dimer cut
10 off level of <2808ng/mL on day 1 post total hip or knee arthroplasty was
11 associated with a significantly lower incidence of subsequent asymptomatic
12 DVT (USS proven) on postoperative day 7 (8% vs 21.4%) [18]. Yoo et al
13 measured d-dimer on day 3 following total hip replacement or surface
14 replacement in 221 patients and found a significant correlation with the finding
15 of DVT on ultrasound/venogram at day 7 postoperative. A cut off value of
16 2640 ng/mL had a negative predictive value of 98.8% [19]. Sudo et al (2009)
17 suggested a cut off level of 17700 ng/mL after hip or knee arthroplasty [20].

18

19 One explanation for the comparatively low levels of d-Dimer found in our
20 study is that our blood samples may have been taken prior to the
21 prothrombotic state occurring. For example, in a study of 99 patients who
22 underwent THR or TKR, d-dimer was measured pre and postoperatively.
23 Patients also had DVT ultrasound scan at day 4 and 10 postoperatively, with
24 15% being found to have a DVT. D-dimer levels were significantly higher
25 postoperatively as compared to pre-operative levels and those who were

1 subsequently found to have DVT had statistically significantly higher d-dimer
2 levels than those who did not, at days 4, 7, 10 and 14 postoperatively.
3 Interestingly, there was no significant difference in d-dimer levels on day 1
4 postoperative between those who subsequently developed DVT and those
5 that did not [20]. An et al measured d-dimer in 177 patients who underwent
6 THR or TKR and found that d-dimer levels peaked 2 weeks postoperatively
7 [21]. Similarly, Yoshioka et al (2010) found that d-dimer measurements within
8 the first 3 days following spinal surgery were not predictive of findings of DVT
9 on screening USS between days 7-10 postoperative. Interestingly, there was
10 a statistically significant difference in d-dimer levels between those who did
11 and did not have DVT, when measured on day 7 postoperative due to a rise in
12 d-dimer in those with DVT. These studies suggests that there is a delay in
13 prothrombotic state and subsequent rise in d-dimer following surgery [22]. In a
14 study by Walenga et al, patients with lower limb cast treatment for soft tissue
15 injury or fracture had blood samples were taken at baseline (time of
16 randomisation), between day 10 and 14 after injury and again at time of cast
17 removal. 18.6% of 188 patients who did not receive thromboprophylaxis
18 developed VTE, which is similar to our findings. All DVT's occurred in the
19 injured leg [11]. In view of this, it appears that deep vein thrombosis is
20 influenced most strongly by either the injury or the cast itself, as opposed to
21 general hypercoagulability. Interestingly, thrombin-antithrombin complex
22 (TAT), which represents thrombin generation, was normal at time of injury and
23 not significantly different at baseline between patients who went on to develop
24 VTE compared with those who did not. However, when compared at between
25 day 10-14 post injury, it was significantly higher in the group who were

1 subsequently found to have DVT [11].

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4 Limitations of our study

5 In this proof of concept study we measured quantitative levels of Tissue
6 factor, IL-6, VCAM-1 and D-dimer. We acknowledge that study may be
7 underpowered to detect statistically significant differences between groups,
8 however the results may assist in planning of larger confirmative studies. For
9 some of these tests, such as for Tissue factor it would have been useful to
10 measure activity, because levels and activity may be independent. Also, we
11 did not measure Tissue factor pathway inhibitor (TFPI), so it is possible that
12 the thrombogenic effect of exposed subendothelial tissue factor secondary to
13 injury may have been prevented by TFPI [23]. We only took blood samples at
14 time of recruitment i.e. within 3 days of injury. It may have provided additional
15 understanding if we had taken further samples at intervals, which would have
16 enabled calculation of trends in levels of biomarkers assessed.

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1 6. Conclusion

2 In this study of patients with acute foot and ankle trauma, we were unable to
3 find an association between levels of plasma Tissue factor, IL-6, VCAM-1 or
4 D-dimer and subsequent development of DVT. Deep vein thrombosis only
5 appears to occur in the lower limb that has been injured and treated with cast.
6 Further larger study is required to determine which biomarkers of thrombosis
7 can be used and when these should be measured in order to identify patients
8 that will subsequently develop DVT.

9

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12 patients who participated and staff at University Hospital of Wales who
13 assisted with this study.

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1 Table 1 – Exclusion criteria

Age >60 years
Use of Hormone Replacement Therapy or Oral Contraceptive Pill
Personal or First degree relative with history of Venous Thrombosis
Hospital admission of major surgery within 3 months
Pregnancy or within 6 weeks postpartum
Any serious medical co-morbidity
Extensive varicosities
Active cancer
Body Mass Index >30 kg/m ²
Known thrombophilia
Achilles tendon rupture

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1 Table 2: Patient Demographics and injury types

	No DVT (Group 1)	DVT (Group 2)
Number of patients	56	21
Males	36	14
Age	37 (18-60)	36 (20-53)
BMI	25 (19-31)	25 (20-32)
Injuries		
Ankle fracture –Weber A	13	1
Ankle fracture - Weber A and 5th Metatarsal fracture	0	1
Ankle fracture - Weber A and undisplaced Talus fracture	1	0
Ankle fracture – Weber B	18	9
Ankle fracture - Weber B and Cuboid fracture	1	0
Ankle fracture - Weber B and 5th Metatarsal fracture	1	0
Ankle fracture - Weber C	1	0
Ankle sprain	4	2
Anterior process of calcaneus fracture	1	0
Cuboid fracture	2	0
Dorsal talonavicular ligament avulsion	2	1
Fifth metatarsal fracture	3	0
Lateral process of talus fracture	1	1
Lisfranc injury	0	1
Medial malleolus fracture	5	4
Navicular fracture	1	1
Posterior malleolus fracture	1	0
Talar neck and Dorsal Talonavicular ligament avulsion	1	0

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1 Table 3: Blood results

2

	No DVT (Group 1)	DVT (Group 2)	
Tissue Factor (pg/ml)	23.92 (SD 17.52)	20.33 (SD 16.83)	p=0.422
Interleukin 6 (pg/ml)	3.91 (SD 13.07)	4.59 (SD 7.03)	u=561.5, z=0.29, p=0.764
VCAM 1 (ng/ml)	552.98 (SD 92.59)	496.84 (SD 114.02)	u=448.5, z=1.58, p=0.111
D-Dimer (ng/ml)	203.5 (SD 225.27)	236.0 (SD 262.95)	u=527.5, z=-0.68, p=0.490

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